HEALTH BENEFITS REGISTRATION FORM
Federal Employees Health Benefits Program

Form Approved:
OMB No. 3206-0160

- Complete Part A and Parts B, C, D, and E as applicable
- Do not separate the copies. Your employing office will certify the completed form and return your copy to you.
- Type or Print Firmly
- Sign and date in Part F.

PART A - *Fill in this part.*

1. Name *(Last, first, middle initial)*	2. Social Security number	3. Date of birth *(mo., day, yr.)*
4. Your home mailing address *(include ZIP code)*	5. Sex ☐ Male ☐ Female 7. Daytime telephone number	6. Are you now married? ☐ Yes ☐ No

PART B - *Fill in this part if you wish to enroll or change your enrollment in the Federal Employees Health Benefits (FEHB) Program.*

1. I elect to enroll in a health benefits plan as shown below. (Copy the information requested below from front cover of brochure of the plan you select.)

Name of plan — Enrollment code

2a. Name of family members	2b. ZIP code	2c. Date of birth (mo., day, yr.)	2d. Sex	2e. Relationship "code"	2f. Social Security number *(See Instructions)*

3a. Do you, your spouse or any other eligible family members have any group health insurance plan other than FEHB? ☐ No ☐ Yes → Complete 3b

3b. Type of insurance ▶ Medicare ☐ No ☐ Yes → *Indicate part(s)* ☐ CHAMPUS ☐ Other private *(specify name)*

PART C - *Fill in this part , as well as PART B, to change enrollment.*

1. Present Plan name	2. Present Plan enrollment code	3. Number of event that permits change *(See Table of*	4. Date of event that permits change *(mo., day, yr.)*

PART D - *Employees Only*

Place an "X" in the box below if you wish NOT TO ENROLL in the FEHB Program.

☐ I elect not to enroll in the Federal Employees Health Benefits Program.

My signature in Part F certifies that I have read and understand the information regarding this election.

PART E - *CANCELLATION*

Place an "X" in the box below if you wish to CANCEL your enrollment.

☐ I elect to cancel my enrollment in the Federal Employees Health Benefits Program. I am currently enrolled under the code shown at the right.

Present Plan enrollment code

My signature in Part F certifies that I have read the information in the instructions regarding cancellation of enrollment and that I understand that I must meet the 5-year requirement to qualify for FEHB coverage after retirement.

PART F - *Fill in this part.*

WARNING: Any intentionally false statement in this application or willful misrepresentation relative thereto is a violation of the law punishable by a fine of not more than $10,000 or imprisonment of not more than 5 years, or both. (18 U.S.C. 1001.)

1. Your Signature *(Do not print)*	2. Date